First Health
Services Corporation

Fiscal Agent for Virginia's Medical Assistance Program - Provider Enrollment Unit Date

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed agreement forms, processing the enrollment may take up to 15 business days. **First Health** is unable to accept altered agreements, agreements via fax, agreements with non-original signatures or agreements on thermal paper.

Enclosed are blank agreement forms. Please verify all required information is complete to expedite the enrollment process.

☒ Signature is in ink on agreement forms.
☒ Agreement forms may not be altered.
☒ Agreements may not be faxed.

1. The beginning date of coverage is based upon the date authorized by the Department of Education.

2. Enclose a copy of your certification from the Department of Education.

3. EMC billing information.

   - Billing by tape, diskette, or dial-up, contact **First Health**-VMAP at (804) 273-6779 for accepted formats.

4. If you have questions, call 1-804-270-5105. Please complete and return to **First Health** at the following address:

First Health
VMAP-PEU

PO Box 26803
Richmond, VA 23261-6803

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

School Division Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	**PAYMENT/CORRESPONDENCE ADDRESS**	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
PROVIDER NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

The provider agrees to provide only the services as licensed and certified by the Department of Education and assures that those individuals providing the services meet the criteria of this certification.

1. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
2. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
3. **The provider agrees to care for patients at the current rate established by VMAP as of the date of service.**
4. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
5. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
6. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
7. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
8. **This agreement may be terminated at will on thirty days' written notice by either party and or by VMAP when the provider is no longer eligible to participate in the Program.**
9. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
10. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**

The provider agrees to submit, no later than the 15th calendar day from the end of the calendar quarter, a certification of State/Local matching funds for all Medicaid payments received during that quarter. The certification will be in the form specified by VMAP, submitted to the DMAS Fiscal Director and signed by the Superintendent of the School Division or his/her designee. Failure to submit this certification by the due date will result in the VMAP denial of Medicaid funding for provision of those Medicaid reimbursed services and subsequent recoupment by the DMAS Fiscal Division.

11. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

Original Signature **Date**

Title

_____City OR _____County of _____

(Area Code) Telephone Number

For First Health's use *only*

Director, Division of Program Operations Date

IRS Identification Name (Required)

IRS Identification Number (Required)

mail **one** completed **original** agreement to: **First Health - VMAP-Provider Enrollment Unit**
PO Box 26803
Richmond, Virginia 23261-6803

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

School-Based Clinic Participation Agreement

If re-enrolling, enter Medicaid Provider # here→ _____ **Enter school division Medicaid Provider # here→** _____

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the professional association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.**
4. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
5. **The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
6. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
7. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
8. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
9. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For FIRST HEALTH's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail **one** completed **original** agreement to:
FIRST HEALTH - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

For Provider of Services:

Original Signature of Superintendent **Date**

Signature of Supervising Physician

_____City OR _____County of _____

IRS Identification Number **(Area Code) Telephone Number**

Supervising Physician's Board of Medicine License Number

Name of Supervising Physician **CLIA Number**

First Health
Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

☐ **MAILING SUSPENSION REQUEST:**

I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

☐ **COMPUTER GENERATED CLAIMS:**

I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

_____
(Service Center Preparing Invoices)

Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

Prior service center code: _____

☐ **SIGNATURE WAIVER:**

I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**

I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803
1-804-270-5105

mail **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

School-Based Clinic Participation Agreement

If re-enrolling, enter Medicaid Provider # here→ _____

Enter school division Medicaid Provider # here→ _____

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____, _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The applicant has a full or part-time physician authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **The applicant shall be free to accept or refuse a recipient in accordance with the principles of the standards of ethics of the professional association of his area of practice. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **Services rendered must be those provided. Payment is to be made only to those providers who actually render the services.**
4. **The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
5. **The applicant agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
6. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
7. **The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
8. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
9. **The applicant agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
10. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
11. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For Provider of Services:

For FIRST HEALTH's use *only*

Director, Division of Program Operations — Date

Original Signature of Superintendent — **Date**

Signature of Supervising Physician

_____City OR _____County of

IRS Identification Number — **(Area Code) Telephone Number**